

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031296

STATE FILE NUMBER

AMENDED

Registration District No. 317
FILED AUG 28 1961Primary Registration District No. 542 Registrar's No. 2300

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis							
b. CITY (if outside corporate limits, give TOWNSHIP only) Ferguson				Length of stay in 1b 5 days		c. CITY OR TOWN Ferguson		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Oak Knoll Nursing Home				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 37 N. Clark Ave.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Delores Middle Edwards Last Edwards						4. DATE OF DEATH Month August Day 14 Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-4-85		9. AGE (last birthday) 76		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Rothville, Mo.			12. CITIZEN OF WHAT COUNTRY U. S.		
13a. FATHER'S NAME Franklin Mayhugh				13b. MOTHER'S MAIDEN NAME Unknown Queisnbery				14. NAME OF HUSBAND OR WIFE William P. Edwards			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Grace Kochis, 41 So. Schluter Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhages Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular disease DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7 PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Month, Day, Year									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION				COUNTY		STATE	
21. I attended the deceased from Dec 7, 1948 to Aug 19, 1961 and last saw her alive on Aug 13, 1961 Death occurred at 405A on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE Leroy L. Johnson MD (Deaf or title)				22b. ADDRESS 8231 Clayton Rd (17)				22c. DATE SIGNED 8/14/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-16-61		23c. NAME OF CEMETERY OR CREMATORY Elliott Grove Cemetery				23d. LOCATION (City, town, or county) Brusswick, Mo.			
24. FUNERAL DIRECTOR White-Mullen Mortuary, Ferguson, Mo.				ADDRESS 8-14-61				25. DATE RECD. BY LOCAL REG. 8-14-61			
				26. REGISTRAR'S SIGNATURE John C. Murphy M.D.							

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Larry M. Shulte

Licensed Embalmer No. 2973

P. O. Address Jerguson

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.